



WASHINGTON STATE
PODIATRIC MEDICAL BOARD
CONFERENCE CALL MINUTES
July 10, 2006

The conference call of the Washington Podiatric Medical Board originated from the Department of Health, 310 SE Israel Road, 2nd Floor, Tumwater, Washington. The conference call commenced at 12:00 p.m.

Board Members Present: David Bernstein, D.P.M., Chair
Stewart Brim, D.P.M., Vice-Chair
Rex Nilson, D.P.M.
James Porter, D.P.M.

Staff Present: Blake Maresh, Executive Director
Maryella Jansen, Deputy Executive Director
Arlene Robertson, Program Manager
Dori Jaffe, Assistant Attorney General
Karen Maasjo, Administrative Staff

DOH Staff Present Joy King, Executive Director, Section 3
Kristin Reichl, Rules Coordinator

Telephone Participants

Susan Scanlan, DPM, Executive Director, Washington State Podiatric Medical Association
Don Hovanscek, DPM, WSPMA Legislative Liaison
Gail McGaffick, Lobbyist for WSPMA
Chuck Martin, Chair, Physical Therapy Board
Rich Bettes, Physical Therapy Association of Washington
Melissa Johnson, Lobbyist, Physical Therapy Association
Paula Dillon Mays, Member, Physical Therapy Board
Patricia Muchmore, Liaison to Physical Therapy Association

1.

Open Session

1. Rules

1.1 Review Physical Therapy Proposed Rules

The Board will review and provide comments relative to proposed rules:
WAC 246-915-360 Sharp debridement education and training and WAC
246-915-370 Electroneuromyographic examinations education and
training.

ISSUE

Dr. Bernstein reviewed the points of concern outlined in his summary of the proposed rules. (Refer to ACTION below.)

The members of the Board discussed the concerns raised by Dr. Bernstein. The board members felt the concerns identified addressed the primary issues of concern. Dr. Porter indicated it would have been more helpful to have a definition of devitalized tissue to specify the depth of the wound.

Ms. Scanlan indicated that the Washington State Podiatric Medical Association felt the statement that "education is assumed" is too vague and does not identify adequate education. The American Physical Therapy Association Minimum Required Skills of Physical Therapist Graduates at Entry Level (2005) does not include sharp debridement. (This is the core document made available to stakeholders including the Commission on Accreditation in Physical Therapy Education (CAPTE), physical therapist academic programs and their faculties, clinical education sites, students and employers.) Ms. Scanlan indicated that it appeared most physical therapists have received sharp debridement training through hospitals or another provider whose scope of practice includes debridement not from their physical therapy training.

Mr. Martin addressed the issue of the physical therapy education. He indicated that the Physical Therapy Board has received confirmation from University of Utah, University of Washington, Eastern Washington and CAPTE that individuals receive adequate education and meet the minimum standard for sharp debridement.

Other participants also provided background and responded to the concerns expressed by the Board.

ACTION

Following discussion of the proposed language and concerns relative to the education and training requirements for physical therapists to perform sharp debridement, the Board approved the following comments and concerns be submitted to the Physical Therapy Board for consideration of WAC 246-915-360 Sharp debridement education and training pursuant to CR 102, WSR 05-19-049.

Re: physical therapy and sharp debridement proposed rulemaking.

Introduction: during the 2005 legislative session House Bill 1137 passed authorizing "a physical therapist to perform sharp debridement, to include the use of a scalpel only upon showing evidence of adequate education and training as established by administrative rule." CR-102 is providing two new sections to the WAC: 246-915-360 for "sharp debridement education and training" and 246-915-370 "electromyographic examinations education and training" to define the

administrative rule for the required education/training for physical therapist to provide these newly established areas of practice.

Review of available information and proposed new WAC.

1. The Board of Physical Therapy has put out an "affidavit of education and training in sharp debridement, including the use of scalpel." This document indicates that physical therapists are required to submit this form if they are to be performing sharp debridement after July 24, 2005. It asks to provide a description of the education and training in sharp debridement including the use of a scalpel. It include the course name, course sponsor, course dates, and hours completed. It also defines sharp debridement "means the removal of devitalized tissue from a wound with scissors, scalpel, and tweezers without anesthesia. A physical therapist may not delegate sharp debridement. A physical therapist may perform wound care services only by referral from or after consultation with an authorized health-care practitioner."

2. The Small Business Impact Statement for these rules concerning licensed physical therapists reports that "the board feels 20 hours of mentored training is sufficient to ensure patient safety because there have been no adverse actions taken against licensed physical therapist performing sharp debridements prior to this legislation. It goes on to estimate the cost to comply with the sharp debridement education rule to be \$600 at \$30 an hour for 20 hours of mentored training. An additional \$330 would be required for them to become certified as a wound care specialist. Regarding electromyographic examinations "the proposed rule requires a minimum 400 hours of instruction... including at least 200 needle EMG studies... the board received correspondence requesting the board increase the minimum hours to 1000." It goes on to state that "approximately, 5 out of 4500 licensed physical therapies currently perform EMGs in Washington. Licensed physical therapists have been performing EMGs for approximately 40 years prior to this legislation. The Department of Health has not received any complaints regarding patient safety involving EMGs. Therefore, the board feels the minimum proposal of 400 hours of instructions and EMG examinations including at least 200 needle EMG studies under direct supervision will ensure the public is protected against unqualified and untrained licensed physical therapists."

3. Significant Analysis for rules concerning licensed physical therapists: in part C. it is noted that "a licensed physical therapist that is certified as a wound care specialist by the American Academy of Wound Management, meet the requirements of the proposed rule." It goes on to indicate that physical therapy for baccalaureate degree programs "currently, wound care education has been put in place in physical therapy schools nationally and is often a component of the didactic classroom education piece and of the clinical rotations." It does not

indicate that it is always included in all curriculums or comment on physical therapy graduates from before wound care material was included in the program. The proposed requirement of 20 hours of mentored training is in addition to this wound care education.

Points of concern:

- How does this rule assure that physical therapists that graduated prior to the incorporation of wound care within the physical therapy degree program are properly trained?
- Who are considered acceptable "mentors"? What is their required education/training in order to be a mentor?
- It seems illogical that a procedure that allows invasion of someone's body by needles would require 400 hours of training (and comments received suggested a 1,000 hours of training) while invasion of someone's body with a scalpel to cut tissue would only require 20 hours of training.
- The debridement of devitalized tissue takes considerable skill. The demarcation between "devitalized" and vital tissue is both literally and figuratively often gray. While debriding wounds, bleeding is often caused, indicating vital tissues have been cut. Inadequate training particularly with regards to potential problems or complications that may arise is critical for public safety. Knowledge of hemostasis, wound healing, anatomical structure, the ability to use hemostatic modality such as cautery, ligation, bioactive agents and so on is a must for those performing wound debridement safely.
- Basic wound care concepts indicate that debridement that is short of complete removal of all dead tissue is inadequate and that the basic principle of creating a "fresh" wound to facilitate healing requires some trauma to vital tissues.
- Many, if not most, of the patients suffering wounds particularly those who may not require anesthesia due to peripheral neuropathy have diabetes. These patients at this point in their disease process are at a very high risk for infection and subsequent loss of limb or life. This requires an extremely well-trained individual to identify even the earliest signs of infection or determine the depth or severity of the infection. This oftentimes requires diagnostic tests that are beyond the scope of physical therapists to order.
- Would the 20 hours of mentored education assure that a physical therapist could recognize the differences and take appropriate steps to care for arterial insufficiency ulcers, venous stasis ulcers, neuropathic ulcers, or pressure ulcers? The treatment for each type is unique and often if the wrong modality is applied will aggravate or worsen the condition threatening the patient's limb and possibly life.
- There are a number of wound care modalities that are prescription only, for example Regranex. How can a physical therapist provide these modalities without prescribing authority?

- Is "passing medications" within the scope of physical therapy? Would applying prescription-only wound care modalities be considered "passing medications"?
- Does the performance of sharp debridement require an order from an authorized health-care practitioner? Does the wound care modality require signoff by the authorized health-care practitioner?

The conference call was adjourned at 1:10 pm.

Respectfully Submitted

Arlene Robertson
Program Manager

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